STATE OFFICIALS PLEDGE AFFORDABLE HEALTH CARE — PAGES 8-9

MIA: Elderly Veterans Ignored PAGE 6

Health Care News

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IRS Backs Free-Market Health Care

BY CONRAD F. MEIER

A federal tax opinion issued by the Internal Revenue Service (IRS) on June 26 is expected to encourage employers nationwide to adopt a type of consumer-driven health insurance that gives consumers greater control over medical expenditures.

Plans affected by the ruling are generally known as Health Reimbursement Arrangements (HRAs) or Flexible Spending Accounts (FSAs). Such plans allow employees to choose their health care services and pay for them out of tax-favored individual savings accounts funded by their employers.

Victory for Consumers

In a consumer-friendly ruling, the IRS makes clear employees are permitted to carry bala nces in their employer-funded accounts from one year to the next, without negative tax consequences. "Use it or lose it" no longer applies.

Doug Kronenberg, chief strategy officer at Lumenos, which offers health care benefits services to several Texas employers, said, "This is tremendous news for everyone involved in employee benefits. It removes the concern surrounding potential tax implications with accumulated savings."

"With this new guidance," explained Treasury Secretary Paul O'Neill in an IRS news release, "we clear the way for employers to adopt health plans with patient-directed features so that employees have more choice and greater control over their health care coverage."

According to Greg Scandlen, senior fellow in health policy for the National Center for Policy Analysis (NCPA), "The IRS ruling will enable employers of any size to adopt an MSA-type pro-

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Peter Jennings' Bitter Mistakes

How ABC's May 29 Special Report slandered the nation's pharmaceutical industry and mis-diagnosed the nation's health care finance problem

BY MERRILL MATTHEWS

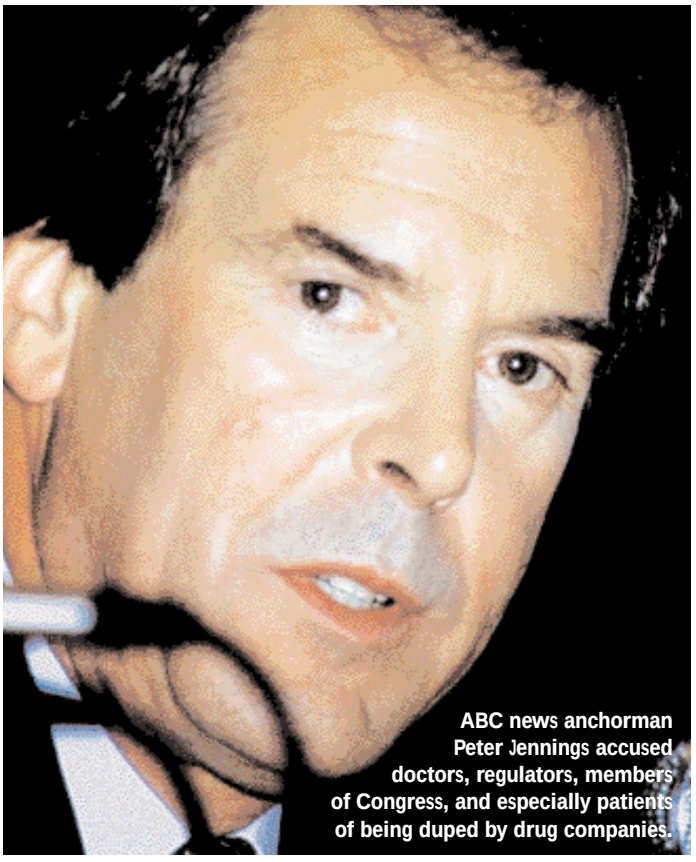
On May 29, ABC aired an hour-long attack on the nation's pharmaceutical industry masquerading as an objective documentary. Narrated by Peter Jennings, the program accused the industry of free-riding off taxpayers, earning "huge profits" by manipulating patents, marketing "me too" drugs instead of finding new cures, and suppressing research exposing the ineffectiveness or dangerous side-effects of its products.

"The documentary's title, 'Bitter Medicine: Pills, Profit and the Public Health,' should have tipped off viewers that the program was not an objective view of a complex subject."

Strong Claims

The documentary's title, "Bitter Medicine: Pills, Profit and the Public Health," should have tipped off viewers that the program was not an objective view of a complex subject. Language used throughout the program was uncompromising and misleading.

Drug companies, Jennings said, earn "huge profits" partly by letting taxpayers finance basic research. Jennings said repeatedly, in a tone indicating he expected viewers to be shocked, that drug manufacturers are allowed to market new products that haven't been proven to be better than those already on the market.



ABC news anchorman Peter Jennings accused doctors, regulators, members of Congress, and especially patients of being duped by drug companies.

Huge Profits?

According to Jennings, the pharmaceutical industry is the most profitable in the country. The likely source for the assertion (Jennings didn't say) is

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Medicaid Rebates on Front Burner

BY JOSEPH BAST

On July 23, the U.S. Senate voted down both Democrat- and Republican-backed bills that would have added a comprehensive prescription drug benefit to Medicare, most likely postponing any action on the long-debated program until 2003. But at the state level, efforts to give consumers a break on high prescription drug prices continue, producing strident election-year rhetoric, litigation, and warnings from the medical community.

Stabenow Medicaid Amendment

On July 19, the Senate voted 56-43 to approve an amendment to a bill on drug patent reform that would give states wider

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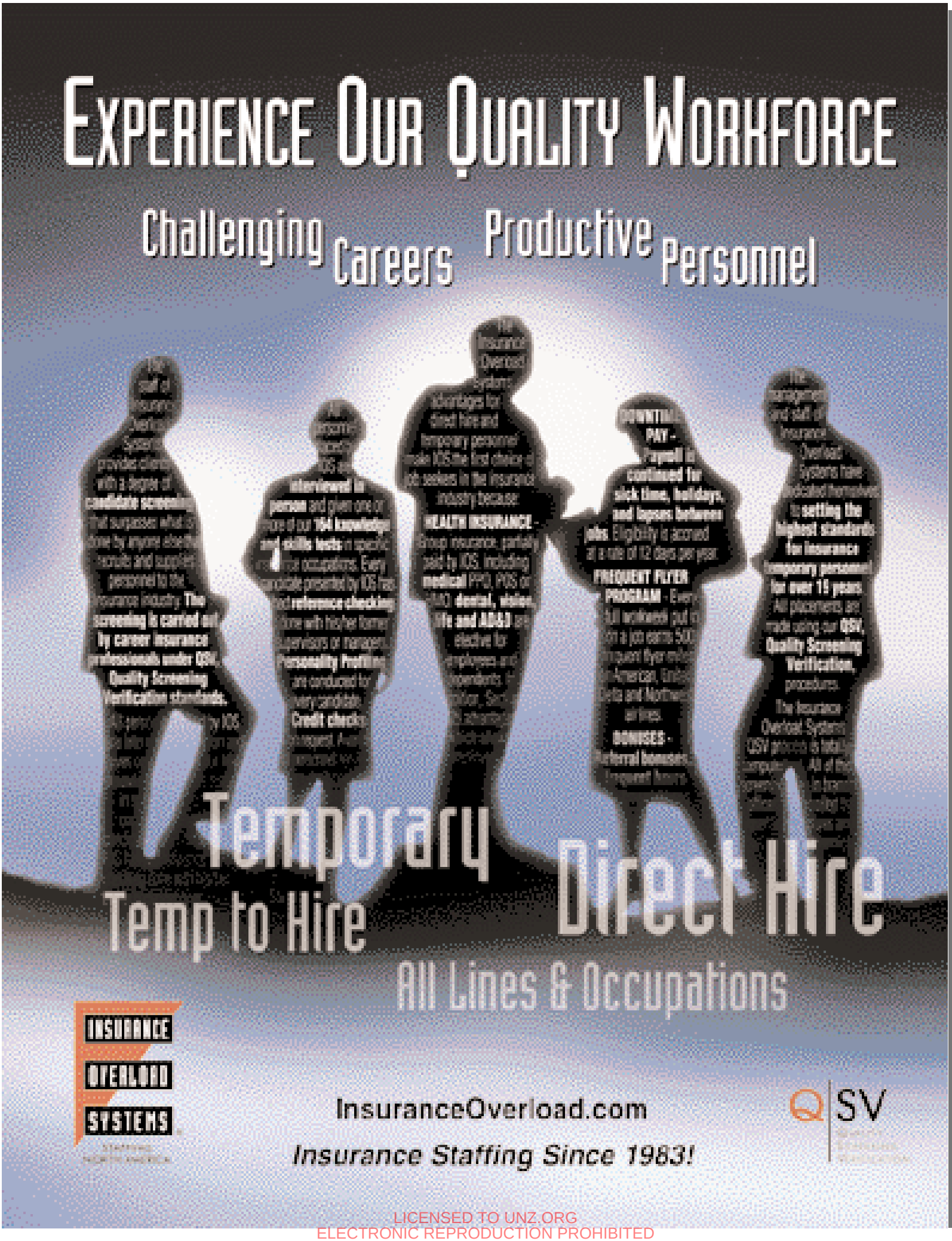

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The PULSE

BY GREG SCANDLEN

FREE-MARKET HEALTH CARE REFORM IN THE NEWS

The National Center for Policy Analysis has released three new health policy-related *Brief Analyses*, one by Ron Bachman of PricewaterhouseCoopers and two by me.

Bachman's, titled "Giving Patients More Control," describes the product design and advantages of Patient-Directed Healthcare Benefits (PDHBs). These products feature high-deductible major medical plans, employer-funded Personal Health Accounts, first-dollar coverage for preventive services, and an FSA or Premium Conversion Plan for employee contributions. Bachman argues such plans can "help lower costs and increase access while offering patients more choices and better medical care."
Source: http://www.ncpa.org/pub/ba/ba399

I wrote one on "Five Steps Employers Can Take Now" to increase consumerism in health care. Those five steps are:

- Letting workers know what their health insurance and health care services cost.
- Allowing cash-outs for employees who can get a better deal elsewhere.
- Eliminating "community rating" within the company to encourage participation by younger employees.
- Offering a wider range of plan options with a fixed contribution by the employer.
- Increasing the amount of direct pay for services, whether through a PHA, MSA, shared-deductible, or any other mechanism to increase price sensitivity.

Source: http://www.ncpa.org/pub/ba/ba398

The other NCPA *Brief Analysis* I wrote summarizes The Commonwealth Fund's recent survey of health care systems in five nations. That report appears on page 1 of this issue of *Health Care News*.

EBRI Equates Defined Contribution with Managed Competition

The Employee Benefits Research Institute (EBRI) released a new issue brief by Len Nichols, "Can Defined Contribution Health Insurance Reduce Cost Growth?" It is an interesting discussion, but frustrating because Nichols equates defined contribution with managed competition—that is, he assumes a DC approach is nothing more than a choice of several health plans selected by the employer with a standardized benefit design and a fixed contribution—and he maintains that new technology is necessarily cost-increasing.

He does concede that, while "the demand for health insurance is considered to be fairly price in-elastic ... plan switching elasticities are much higher." So, "whereas a 10 percent premium increase might induce only a 5 percent reduction in the probability of purchasing health insurance at all, a 10 percent premium differential ... might engender as much as a 50 percent reduction in the market share of the high-priced plan."

Because employer-sponsored coverage represents only 27 percent of total health care costs, he argues, even a major cost reduction will have little effect on total national health expenditures. The paper would be stronger if it also considered the effects of more direct pay by patients, and how that might force new technologies to be more cost-effective.
Source: EBRI will send you an electronic version of the paper for $7.50. Go to http://www.ebri.org

EBRI Conference Asks about Controlling Technology Costs

EBRI also held a conference on consumer-driven health care, according to an article by Jill Elswick in *Employee Benefit News*. EBRI's Paul Fronstin made the point that 50 to 60 percent of health care inflation can be attributed to technology, and asked how consumer-driven plans would address this. Michael Parkinson, chief medical officer at Lumenos, replied that 70 percent of family doctors will prescribe drugs they don't think are needed because patients request them. Having a financial stake would change that, he said.

A Definity representative said its consumers use nurse hotlines twice as often as managed care patients do and their costs are 15 percent lower than managed care alternatives. One of Lumenos' accounts, Pharmacia, reported there were no selection problems with the plan.

But Delta Airlines' Miles Snowden said he couldn't see contributing dollars to an account for someone who would otherwise consume no services. He was also nervous about the lack of guidance from the IRS, and by the prospect that workers would try to max-out their health account before leaving the company since they would otherwise forfeit the balance. (*Managing Editor's note*: See page 1 for coverage of recent favorable rulings by the IRS.)
Source: http://www.benefitnews.com/health/

UCLA Survey Sees Substantial Cost Sharing

The nation is entering into a massive real-time experiment on what direct pay will do to health care costs as more and more companies decide they simply cannot absorb cost increases of 20 percent and more.

Don Lee reports in the *Los Angeles Times* that a new survey by UCLA shows employers "are preparing to make substantial changes in health plans to shift more of the burden of rising premiums to workers." He writes, "about 75 percent of the managers polled said they were somewhat or very likely to substantially revise their health plans when annual renewals come up." One broker reports her clients are seeing rate increases from 10 to 30 percent.

The article reports that "so far ... no one has dropped coverage, but some have boosted deductibles and switched from a regular HMO to a cheaper plan with fewer benefits."

The story also says there is "no rush to switch to so-called defined contribution plans," but the employers seem to misunderstand what this means, because "employers are hesitant to offer these plans because of tax consequences and the uncertainties of leaving it up to the employees to buy private medical coverage, which typically is more expensive."
Source: http://pqasb.pqarchiver.com/latimes/search?QryTxt=%22defined+contribution%22&x=8&y=1

Supreme Court Okays State Review Panels

The U.S. Supreme Court issued an unsurprising decision that state-based independent review panels (for HMO decisions) do not violate ERISA because they fall within the "savings clause," which reserves the regulation of insurance companies to the states. Such panels will continue to be pre-empted for self-insured employer plans, but not for "fully insured" plans (which most HMOs are).

The decision is unlikely to have any impact on the federal Patients Bill of Rights, but it may encourage employers to reduce their HMO options and encourage more use of self-funded PPOs instead.
Source: The decision may be downloaded at: http://a257.g.akamailtech.net/7/257/2422/20jun20021230/www.supremecourtus.gov/opinions/01pdg/00-1021.pdf

Greg Scandlen is senior fellow in health policy at the National Center for Policy Analysis in Dallas, Texas and assistant editor for Health Care News. *To sign up for his free weekly e-newsletter,* Scandlen's Health Policy Comments, *log on to http://www.ncpa.org/sub. Email Scandlen at GMScan@aol.com.*

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New Efforts Underway to Inject Competition into Medicare

Reform process characterized by fits, starts, and small steps in the right direction

BY TOM MILLER

In 2001, efforts to build momentum for further privatization in the federal Medicare program came up short. The existing Medicare+Choice (M+C) program was plagued by withdrawals and service reductions by private health plans. It failed to gain more than a handful of plan participants representing newly authorized types of options, such as preferred provider organizations.

But the proponents of competition don't give up easily. Renewed efforts are underway to improve and expand private health insurance options for seniors.

Medicare+Choice in Decline

The 1997 Balanced Budget Act (BBA) attempted to address several problems plaguing the Medicare program, including the fact that private plan alternatives to traditional fee-for-service (FFS) Medicare were limited to health maintenance organizations (HMOs) available primarily to seniors in larger metropolitan-area markets.

The BBA did manage to achieve significant cost reductions, largely by reducing payments to doctors and hospitals. It also launched a Medicare+Choice (M+C) program intended to make it easier for seniors to opt out of FFS Medicare and acquire health coverage in the private sector.

Even though the M+C program aimed at offering consumers more choice, only about 14 percent of the 40 million Medicare beneficiaries were enrolled in a private plan during 2001—a smaller percentage of Medicare beneficiaries than before the 1997 BBA. As of August 2001, the number enrolled in M+C was 5.6 million, down 10.5 percent from the December 2000 total of 6.26 million enrollees.

The decline in enrollment was accompanied by a sharp reduction in the number of plans participating in M+C. In 2001, withdrawals and reductions affected an estimated 934,000 M+C enrollees. At the beginning of January 2002, another 536,000 enrollees were likely to be dropped from M+C plans curtailing their participation in Medicare.

The BBA had expanded the authority of the Health Care Financing Administration (since renamed the Centers for Medicare and Medicaid Services, or CMS) to fund a variety of private insurance policies as voluntary alternatives to the traditional Medicare FFS program.

The private insurance options included health maintenance organizations (HMOs), preferred provider organizations (PPOs), provider-sponsored organizations (PSOs), private fee-for-service (FFS) insurance plans, and medical savings account (MSA) plans. Very few insurers offering PPOs have applied for an M+C contract since the BBA passed (two M+C plans currently offer PPO products), and no insurance carrier has offered a Medicare MSA plan.

Sterling Life Insurance began offering the first private FFS option in July 2000 and currently operates in about two dozen states (primarily in rural areas where other M+C options are not widely available). It offers open provider choice, combines Medicare and supplemental benefits, and pays providers on a fee-for-service basis. As of August 2001, it served just 18,000 Medicare beneficiaries, but its enrollment was growing.

Small Step in the Right Direction

M+C represents a small step toward a different system of health care financing, based on "defined contributions." It allocates government payments to private insurers on the basis of individual county rates multiplied by risk factors for each beneficiary covered in a given private M+C plan. These risk factors are supposed to reflect the expected cost of serving each person.

"[T]he proponents of competition don't give up easily. Renewed efforts are underway to improve and expand private health insurance options for seniors."

It should be easier to control total Medicare expenditures if more beneficiaries receive M+C defined contribution payments instead of Medicare FFS reimbursements for a set of defined benefits. Paying a fixed dollar amount per person is more predictable than paying after-the-fact for a set of promised services.

Before passage of the BBA, there was tremendous variation in county-level per-capita spending in the Medicare FFS program, depending on differences in the utilization of Medicare and the local costs of medical services. Beneficiaries in higher-spending areas gained the advantage of relatively higher payment rates for private plan alternatives, which attracted more HMOs (and more generous supplemental benefits packages) to their areas.

Politics Stymie Competition

The BBA established a new payment method, designed to limit geographic variation in M+C payment rates. Congress decided to increase payments to M+C plans in counties with low rates and limit increases in higher-paid counties. However, the new BBA payment rules have had only a modest effect in "compressing" the range of county payment rates thus far.

The BBA also tried to address other concerns: for example, that Medicare's payment method for private plans failed to adjust for the fact that beneficiaries enrolled in HMOs generally were healthier (and less costly to insure) than those who remained in the traditional Medicare FFS program. Inadequate "risk adjustment" added to the uneven pattern of enrollment in private plans and wide variation in their benefits packages.

The pre-BBA payment rules for Medicare managed care meant the program paid too much in some markets (particularly for plans that enrolled healthier beneficiaries) and too little in other markets. Those payment policies limited the benefits from more efficient managed care and discouraged beneficiaries from making cost-conscious choices. The BBA required HCFA to begin making payments to M+C plans on January 1, 2000 using a new risk-adjustment method that took into account health status differences among their beneficiaries, in order to reflect more closely the expected cost of serving each person

There were so many objections to the new risk adjusters (particularly the use of data from ambulatory settings and other non-hospital in-patient encounters) that Congress first stretched out the transition to full risk adjustment, and then largely set the requirement aside until 2004. In September 2001, CMS Administrator Thomas Scully suspended collection of ambulatory encounter data for a year and put further implementation of risk adjustment on hold.

Payments based on diagnoses as well as demographic factors may eventually give insurers more incentive to keep patients who have potentially costly problems. Thus far, the new risk-adjustment rules for payments have had little effect in that regard.

Carmen Miller and Delia Bustamonte react to President George W. Bush's address to the Coalition for Medicare Choices in the East Room of the White House on May 17, 2002. *photo/Chuck Kennedy*

Framework for Reform

In response to the above trends and developments in the M+C program, the Bush administration on July 12, 2001, offered The President's Framework to Strengthen Medicare. The plan included a voluntary drug discount plan for Medicare seniors, but its administrative implementation was delayed by a court challenge. The rest of the framework proposed principles rather than legislative details. It emphasized:

- Current seniors (and those near retirement age) must have the option of keeping their traditional Medicare benefits "exactly the way [they are] today."

"[Medicare+Choice] represents a small step toward a different system of health care financing, based on 'defined contributions.'"

- A range of new, competing Medicare plan options must offer subsidized prescription drug benefits.
- Medicare should provide true stop-loss protection from high expenses; impose no cost-sharing for preventive benefits; and charge lower co-payments for hospitalizations.
- Medicare should encourage high-quality care and provide better benefits.

The President underplayed several of the key ingredients needed to make such improvements affordable: allowing private plans to bid to provide required benefits, letting beneficiaries capture the savings from less-costly options, and eventually requiring the government's share of Medicare funding to reflect the average costs of the mandatory benefits provided in private plans as well as traditional Medicare (a level-playing-field payment system).

MEDICARE continued on next page

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Medicare Is Losing Talent

Over-regulated and underpaid, doctors refuse to see Medicare patients

BY ROBERT E. MOFFIT, PH.D.

A growing number of U.S. physicians are refusing to accept new Medicare patients, and some physicians are withdrawing from Medicare altogether. The reason: Medicare's complex system of administrative pricing is cutting physician reimbursements by 5.4 percent this year while forcing frustrated doctors to comply with an ever-growing body of incomprehensible rules and regulations.

"For years," writes Robert Pear, veteran reporter on health care policy for *The New York Times*, "doctors have expressed frustration with Medicare, grumbling about reimbursement and complex federal regulations. But the latest reaction appears to be different. Doctors are acting on their concerns, in ways that could reduce access to care for patients who need it."

"Medicare patients must often wait while patients in the private sector receive much quicker access to new medical services and technologies."

In spite of the sobering news, the American Association of Retired Persons (AARP) strongly opposes increased payments to doctors and other providers in Medicare unless Congress first agrees to provide a "meaningful" prescription drug benefit in the Medicare program—a benefit that, under AARP's own definition, would cost no less than $750 billion over 10 years.

That is far in excess of leading administration and congressional proposals and would guarantee a sharp acceleration of the rapidly rising cost of the financially troubled Medicare program. In making this demand, AARP is, in effect, holding doctors and other medical professionals hostage even though they, as a class, may not have any specific stake in the cost, design, or structure of the Medicare prescription drug benefit.

Archaic Central Planning

Medicare is a system of central planning and price regulation in which virtually every aspect of the financing and delivery of medical services to senior citizens is under bureaucratic control. Congress and the Centers for Medicare and Medicaid Services (CMS), the federal agency that runs Medicare, define which benefits, medical services, and treatments or procedures seniors will (or will not) have available to them in the program.

With every benefit change, biomedical breakthrough, or innovation in technology or service delivery, Congress must change the law or authorize the Medicare bureaucracy to make the appropriate adjustments in changing the benefits or adding services or procedures.

This process is painfully slow and inefficient. Medicare patients must often wait while patients in the private sector receive much quicker access to new medical services and technologies.

The medical community has long lamented the morass of red tape, sluggish and inappropriate payments for services provided, and more recently fears of retaliation for even unintentional noncompliance posed by the current Medicare system. The emerging refusal of physicians to see Medicare patients is a new and ominous development that, if brought to the attention of Congress and the Bush administration, could prompt long-overdue substantive reform.

Steps toward Reform

Senior citizens' reduced access to care and the deepening demoralization of doctors are rooted in the outdated structure of Medicare itself. Instead of relying on Medicare's central planning and price regulations, Congress should enact structural changes that would enhance patient choice and control over health care decisions and move toward a more rational system.

A model for such reform exists in the popular and successful Federal Employees Health Benefits Program (FEHBP), the patient-centered, consumer-driven system that covers members of Congress, federal workers and retirees, and their 9 million family members.

To address the problems of Medicare before they reach crisis proportions with the forthcoming retirement of the 77-million-strong baby-boom generation, Congress and the administration should act quickly to initiate reform in the system. Specifically, they should:

- Increase Medicare payments to doctors practicing in the Medicare program, reversing the 5.4 percent cut in this year's Medicare physician reimbursement.

"Senior citizens' reduced access to care and the deepening demoralization of doctors are rooted in the outdated structure of Medicare itself."

- Intensify their review of the regulatory burdens facing doctors and other providers in the Medicare program and give them timely regulatory relief.
- Continue to press for comprehensive Medicare reform. Congress and the administration should start to create a new competitive system modeled after the FEHBP.

Such a new system, based on patient choice and a competitive market, would enhance the quality of health care for a growing number of senior citizens and improve the working environment for physicians. The new competitive system would be characterized by rapid innovations in benefits and the efficient delivery of medical services, free of the sluggish bureaucratic process and red tape that hobble benefit-setting in the current Medicare program.

Doctors, Medicare patients, and the taxpayers who fund this system deserve such reform.

Robert E. Moffit, Ph.D., is director of domestic policy studies at The Heritage Foundation.

For more information…

WWW This article summarizes Robert Moffit's April 22, 2002 Heritage Foundation *Backgrounder* No. 1539, "Why Doctors Are Abandoning Medicare and What Should Be Done About It," available online at **http://heritage.org/library/backgrounder/bg1539.html**.

MEDICARE continued

Promising Demonstration Derailed

However, a once-promising vehicle for demonstrating the benefits of competitive alternatives to Medicare price controls—the Medicare competitive pricing demonstrations originally mandated by the BBA—was derailed by a congressional appropriations rider in November 1999. When the final report of the Competitive Pricing Advisory Committee was issued on January 19, 2001, it concluded "the key impediments to competitive pricing are not conceptual or practical, but rather political."

Relatively little congressional activity toward Medicare reform occurred during 2001. Senators John Breaux (D-Louisiana) and Bill Frist (R-Tennessee) reintroduced their Medicare Preservation and Improvement Act (S 357), which would create a competitive premium system in which both traditional Medicare and private plans would submit premium bids for the "standard" and "high option" plans they decided to offer. Beneficiaries would receive varying levels of "premium support" subsidies (no more than 85 percent of the national average premium), depending on the premiums charged for a particular plan's "core benefits." The proposal sets various regulatory limits on the range of private plan competition, in such aspects as cost sharing, benefit design, and service area.

"The long-term route to greater privatization of Medicare choices remains moving from the program's traditional defined benefit structure to a defined contribution/ premium-supported model ..."

Sen. Bob Graham (D-Florida) introduced a more limited measure, The Medicare Reform Act of 2001 (S 1135). The bill focused primarily on improving the FFS Medicare program and integrating a new prescription-drug benefit into the traditional program's structure. The bill would provide CMS with additional resources and authority to implement purchasing, contracting, and quality improvement techniques (coordinated care, disease management, competitive pricing, preferred provider options) that have been used successfully in the private sector.

Neither the Breaux-Frist bill nor the Graham proposal moved toward any formal markup at the committee level during 2001.

Reform Badly Needed

The long-term route to greater privatization of Medicare choices remains moving from the program's traditional defined benefit structure to a defined contribution/premium-supported model, under which seniors could choose among competing benefit packages with taxpayers' costs capped at preset levels. Healthy competition would give the FFS Medicare program an incentive to improve and fight for market share on a level playing field. Seniors seeking supplemental benefits would pay additional premiums reflecting their marginal costs, and their value.

Defined contribution payments would need to be determined by competitive market prices, instead of bureaucratically administered prices. Competitive bidding mechanisms and reasonable ground rules for periodic open enrollment would provide the best mechanism for this task, but political support for those tools has been fleeting at best.

Tom Miller is director of health policy studies for the Cato Institute. This article is excerpted from his contribution to Privatization 2002: 16th Annual Report on Privatization, *published in April 2002 by the Reason Public Policy Institute. For more information on the report, visit RPPI's Web site at* http://www.rppi.org.

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Elderly Veterans Ignored in Rx Policy Debate

BY CONRAD F. MEIER

Millions of retired elderly veterans eligible for benefits under the U.S. Department of Veterans Affairs' (VA) health care system have been largely forgotten in current health care policy debates. Nowhere is this more problematic than in the discussion of prescription drug policy.

Thousands of retired military personnel wait years just to see a Veterans Health Administration doctor. The system is struggling mightily to cope with a rapidly increasing patient population and rising drug costs.

Queuing Commonplace

At Bay Pines Veterans Medical Center, outside St. Petersburg, Florida, more than 4,400 veterans will have to wait until October 2005 for their first doctor appointment. According to current VA policy, only a VA doctor can write a prescription to be filled by a VA pharmacy.

In parts of Arizona, Florida, Iowa, Kansas, Missouri, and Nebraska, veterans wait months just to enroll at clinics. Enrollment is open to all honorably discharged veterans with at least two years of service. The service requirement does not apply to those discharged before September 7, 1980 or to one-time members of the National Guard or U.S. Army Reserve who were called to active duty.

Once enrolled, veterans find the VA a daunting adventure in frustration caused by rationing services to control costs. Administrators, frustrated as well, have proposed limiting eligibility to reduce the number of beneficiaries and using an income test to increase prescription drug copayments.

VA officials acknowledge reform is necessary. As the U.S. population generally is aging, so is the population of veterans. Without reform, the strain on the veterans' health care system will only get worse over time.

System Sprawl

America's 25.5 million veterans are already older, on average, and more dependent on medication than the general senior citizen population in the U.S. Nine million veterans remain from World War II and the Korean War. There are now 510,000 veterans 85 or older, and the VA predicts there will be 1.2 million by 2010.

The number of veterans enrolled in the sprawling VA network of clinics, hospitals, and pharmacies has doubled since the mid-1990s, to six million. The department's pharmaceutical costs have more than doubled, from $1.1 billion in 1996 to $2.9 billion in 2001. Congress increased the VA health care budget just 42 percent over that five-year period.

According to the Department of Veterans Affairs, 163 hospitals, 137 nursing homes, and 850 outpatient clinics, staffed by 15,000 doctors and 30,000 nurses, are part of the VA network. In an effort to bring services closer to where many veterans live, the VA has added 400 clinics since 1996.

Not all health care facilities in the VA network experience excessive queuing. As older veterans migrate to the South, Southwest, or Midwest, they cause excess capacity in the facilities they leave behind, and inadequate capacity in the facilities that serve their new homes.

"There is adequate capacity in the total, but it's mostly in the wrong place," explained one doctor, who requested anonymity, at the Truman Memorial Hospital in Columbia, Missouri. "Until Congress understands the logistics of the problem, the system will continue to short-change our veterans." He called the rule that VA beneficiaries must have their prescriptions written by VA doctors for filling at VA pharmacies "a classic example of mis-micromanagement that only adds to the queue."

Category 7

In 1996, during the Clinton administration's tenure, veterans won an expansion of health care benefits allowing any veteran to use the VA system of hospitals, clinics, and pharmacies under the rules of Category 7. The military-style code is for those veterans who are not disabled or low-income and do not have service-connected medical problems. The floodgates opened and enrollment doubled as the system took on thousands of veterans fleeing the private health care system, where benefits are shrinking.

Most veterans enrolled in recent years have been in Category 7, drawn in by the advantage of low-cost prescription drugs. The VA increased Category 7 drug copayments last year, to $7 a prescription from $2, but even the new charge is well below the copayments some private health plans require for some drugs. Charges at VA facilities are adjusted by income, with some low-income veterans still paying only $2 for a prescription filled at a network pharmacy.

The department has also tried to control costs by rationing some services, but most efforts are met with protests by veterans' groups and some politicians and have been blocked on Capitol Hill.

Last November, for example, Secretary of Veterans Affairs Anthony J. Principi announced he would suspend new enrollments by Category 7 veterans in fiscal year 2003. But the plan was short-lived, as President George W. Bush promised during budget negotiations the VA would get extra money to cover Category 7 veterans. For the current fiscal year, the administration included $142 million for the VA in its request for additional appropriations for the Pentagon.

Fixing the System

According to research by the National Center for Policy Analysis (NCPA) the best solution is not more V.A. hospitals or more money. What is needed, say NCPA policy experts, is a GI Health Care Bill as a provider of last resort for veterans.

When Congress created the GI Bill, it permitted veterans to choose the type of college or vocational school they wanted to attend. Our colleges are better for the competition the GI Bill created, and our veterans received a quality education, exercising the same choices available to other citizens.

A GI Health Care Bill would provide eligible veterans with a voucher they could use to purchase a traditional health insurance policy, a Medical Savings Account (MSA), an HMO membership, or even premium support for veterans still employed and covered by group insurance.

The NCPA notes, "Such a bill would give veterans the same options as the privately insured." For veterans with known high medical expenses, the voucher could be used to pay for coverage under the private-sector/state-run partnership plan typically known as high-risk insurance pools.

If all veterans have access to private health insurance, there would be no need for the VA hospitals, clinics, nursing homes and other capital equipment. According to the VA, its capital equipment is worth close to $6.0 billion. Selling it, says NCPA, "...perhaps to private hospital systems, could generate significant income for the U.S. government. This money could be invested in treasury notes and the interest applied to the cost of the GI Health Care Bill."

The NCPA notes, "With these options, veterans would have the same choices as everyone else. Our politicians would have one less pork barrel to empty. And our veterans would not face waiting lines or substandard health care. Having served our country so well, they deserve better."

The Bay Pines Veterans Medical Center in St. Petersburg, Florida, is a 966-bed hospital with a very active outpatient load. The occupational/environmental health clinic patients include hospital employees (3000) and volunteers (1000). There are also veterans who reportedly were exposed to the environmental hazards during service (e.g. Agent Orange, ionizing radiation, Persian Gulf war, mustard gas, etc.). Approximately 20 patients are seen each day with a variety of problems, including acute musculoskeletal injuries. *photo/http:///hsc.usf.edu/erc/*

Medicare's Problems Affect Vets

The challenges faced by the veterans health care system have been compounded by Medicare's continuing crisis.

Many private doctors, frustrated by low reimbursement rates, are refusing to accept new Medicare patients, including elderly veterans. Faced with rapidly rising prescription drug costs, Medicare HMOs and some employer-sponsored health plans covering military retirees have stopped paying for certain classes of drugs. Others are requiring higher prescription copayments.

In this environment, the Veterans Administration (VA) has become the default drug store for veterans seeking low-cost prescription medicines. "As some HMOs have gone out of business, we have seen a shift to the VA," explained Dr. Frances M. Murphy, who served as acting undersecretary for health until Robert Roswell's confirmation in March.

The strain on the veterans health care system adds pressure to Congress's efforts to adopt a drug benefit for Medicare beneficiaries. The potential cost of such a benefit—by some estimates, as much as $800 billion over 10 years—has been an enormous hurdle.

Dr. Gail Wilensky, who heads a presidential task force on veterans' health care and was a Medicare administrator in the first Bush administration, believes a new Medicare drug benefit is "at least a couple of years off." Such a benefit might be enacted after the Presidential election of 2004 or 2008, she predicts, when a political consensus has been forged.

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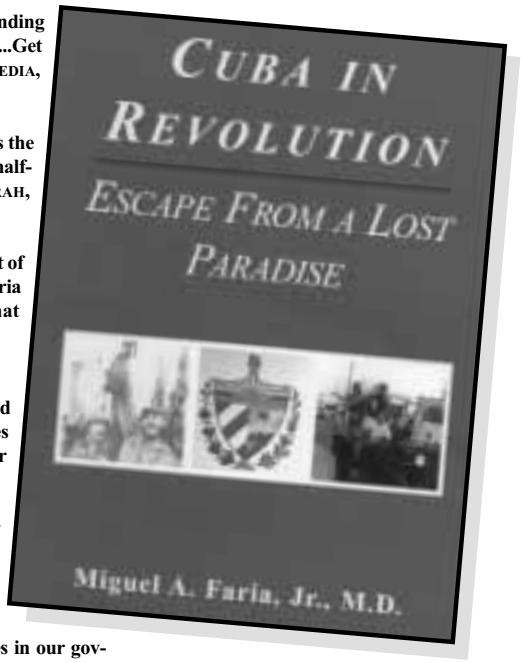
Here's What the Pundits Are Saying!



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"In *Cuba in Revolution—Escape From a Lost Paradise*, Dr. Faria explodes the myths skillfully created by Havana's propaganda machine over the last half-century...Carefully documented, expertly researched..."—Joseph Farah, CEO, WorldNetDaily.com

"America's recent political history is marked by the gradual abandonment of freedom for the promise of government-provided security. Dr. Miguel Faria knows better than most the danger that lies down that path. I pray that enough people read his book...and learn...before it is too late!"
—Neal Boortz, Nationally-Syndicated Radio Talk Show Host

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"Dr. Miguel Faria has shown two things that strike me as essential for Americans to understand. One, gun registration was the tool for Castro to disarm the people of Cuba prior to committing genocide. Two, be careful lest we get what we say we want. The people of Cuba wanted to get rid of the dictator Batista. They did, and then got Castro. I hope that Americans will be more careful about who they support for making needed changes in our government."—Larry Pratt, Executive Director, Gun Owners of America

"...a powerful account of life inside the hemisphere's last authoritarian state!"—Tucker Carlson, *The Weekly Standard*, co-host of CNN's *The Spin Room*

"A shocking, firsthand look into the soul of Cuba's infamous dictator, Fidel Castro, what influenced him, and how he and his brother Raul's 26th of July movement, with its egalitarian ideals, took control of an embattled island and its unsuspecting people...."
—John McCaslin, Syndicated Columnist, *The Washington Times*, Chicago Tribune Media Services

"...Faria makes the case for freedom with the passion and eloquence of one who knows what life is like without it. *Cuba in Revolution—Escape From a Lost Paradise* is an inspiring and exhilarating read."—Jeff Jacoby, *The Boston Globe*

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Miguel A. Faria, Jr., M.D.
Editor-in-Chief of the *Medical Sentinel* of the Association of American Physicians and Surgeons (AAPS) and author of *Vandals at the Gates of Medicine* (1995) and *Medical Warrior: Fighting Corporate Socialized Medicine* (1997).

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Council for Affordable Health Insurance

August 7, 2002

Dear Legislator:

The economic slowdown will result in an estimated 1 million people losing their health insurance in 2002. In addition, health insurance premiums are going up, on average, about 15 percent, but many people and businesses are seeing increases in the 30 percent to 40 percent range.

Is there something that legislators at the state and federal levels can do? Yes, *avoid making the problem worse!*

Every year a small but vocal group of people calls on state legislators and Congress to "fix" the problems in the health insurance market. Almost every time elected officials have responded to those pleas, they have made the situation worse—increasing the cost of health insurance and the number of uninsured.

It is time for that to stop. The Council for Affordable Health Insurance, a research and advocacy organization promoting affordable health insurance, calls on elected officials to oppose legislation that would drive up the cost of health insurance. If anything, they ought to be adopting policies that make health insurance more affordable—such as greater access to Medical Savings Accounts and tax credits for the purchase of health insurance—not less so.

In order to identify the "Friends of Affordable Health Insurance," CAHI and numerous other organizations are asking elected officials to sign the pledge on the facing page. We intend to recognize, publicize and promote the names of those who say NO to laws that make health insurance more expensive.The pledge does not take a stand on any specific legislation; it takes a stand on principle.

If you support affordable health insurance, we ask you to sign the pledge form and send us a photocopy. If you'd like a handsome pledge certificate more suitable for framing, contact me and I'll have one sent to you.

We want to let everyone know who can be counted as a friend of the uninsured—and who only makes the problems worse.

Faithfully,

Merrill Matthews, Jr., Ph.D
Director

112 S. West Street, Suite 400, Alexandria, VA 22314 ◆ Phone: (703) 836 - 6200 ◆ Fax: (703) 836 - 6550 ◆ e-mail: mail@cahi.org
Website: www.cahi.org

Attention: State Legislators! Send your photo and we'll publicize your stand in *Health Care News!*
Mail to: The Council for Affordable Health Insurance, 112 S. West Street, Suite 400, Alexandria, VA 22314

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Pledge Signers Committed to Affordable Health Care

MIKE PENCE
U.S. House of Representatives
Indiana Congressional District 2
Republican
"The number of uninsured is growing, and Congress should not do things to make the problem worse. That's why I signed the CAHI pledge: to oppose harmful legislation and support CAHI's efforts to ensure that all Americans have access to affordable health insurance."

BETSY L. CLOSE
Oregon House of Representatives
Republican - District 15
"With government mandates contributing to higher and higher health care costs, it is time for those of us in government to put on the brakes. The cost of care is increasing much faster than wages and true market conditions do not exist to keep costs in check. We need to take ownership of our own health care decisions. Adding mandates and additional services onto an already burdened system is counterproductive."

MARTHA S. KLIMA
Maryland House of Delegates
Republican - District 9A
"Maryland leads the nation with 50 health insurance mandates. These government-imposed mandates have increased the cost of health insurance to a point where many can no longer afford it. That's why I signed the CAHI pledge, to make sure that ill-planned government schemes do not keep affordable health insurance from those that need it."

SUE BURMEISTER
Georgia House of Representatives
Republican - District 114

KAY O'CONNOR
Kansas State Senate
Republican - District 9

BRYAN RILEY
Candidate for Kansas
Insurance Commissioner
Republican
"I call upon every candidate for office in Kansas to sign this pledge so that we can help make health insurance affordable for ALL Kansans."

STEVE CLOUSE
Alabama House of Representatives
Republican - District 93

ANDREW C. RICHNER
Michigan House of Representatives
Republican - District 1

ALLAN WALTERS
Montana House of Representatives
Republican - District 60

Friend of Affordable Health Insurance

Whereas, 39 million Americans do not have health insurance today;

Whereas, the Congressional Budget Office reports that every 1% increase in the cost of health insurance causes 200,000 people to drop their coverage;

Whereas, access to affordable health insurance is important to all Americans;

Be it resolved, that I pledge to citizens of the state of ____ and to the American people that:

I will oppose any and all legislation that would lead to an increase in the cost of health insurance for working families or the number of uninsured Americans.

signed *date*

The Council for Affordable Health Insurance ★ 112 S. West St. ★ Alexandria, VA ★ 22314 ★ (703) 836-6200 ★ www.cahi.org

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PETER JENNINGS' BITTER MISTAKES

JENNINGS continued from page 1

Fortune magazine's annual ranking (in the April 15 issue this year) of the top 500 companies. The 14 companies that make up the "pharmaceuticals" category had a median profit (as a percent of revenue) of 18 percent, more than any other industry's median.

Jennings did not report the profitability of individual companies. The most profitable drug company on the *Fortune* list is Amgen (28 percent). Three other companies came in at 24 percent. Pharmacia and Abbott both report 7 percent, according to *Fortune*, and Gemzyne was at negative 9 percent.

Compare this to Coca-Cola's 20 percent profit; Bank of New York (19 percent); Mellon Financial (33 percent) (more than any drug company); Microsoft (29 percent); Oracle (24 percent); Gannett (publisher of *USA Today*) (13 percent); Knight-Ridder (15 percent); AT&T (13 percent); and SBC Communications (16 percent). Even the *Washington Post* earned a 10 percent profit, as much as or more than four of the 14 drug companies on the list.

Yes, most of the drug companies are profitable, but no more so than many other companies in other fields. There are companies in other industries that are even more profitable . . . and a Coca-Cola never saved a life.

Enough Innovation?

"Bitter Medicine" suggested there are fewer original drugs being produced today than in the past. The actual record contradicts this: Twenty new drugs were approved by the Food and Drug Administration (FDA) in 1988 and 23 in 1989, compared to 27 in 2000 and 24 in 2001.

The pharmaceutical industry invests about 17 percent of sales in research and development, more than nearly any other industry and well above the average for all industries of 3.9 percent. Compared to drug companies, the computer software and service industry invests 60 percent as much, telecommunications companies just 29 percent as much, and the automotive industry just 24 percent as much.

"Many diseases without cures affect smaller populations, making it more difficult for drug companies and investors to justify the high cost of getting a drug approved."

One industry critic featured by Jennings claimed drug companies get a free ride from spending on basic research by the National Institutes of Health (NIH), and that all five of the best-selling drugs today were funded by the NIH. But according to the Pharmaceutical Research and Manufacturers Association (PhRMA), the trade association for the manufacturers of innovative drugs, industry outspent NIH $26 billion to $18 billion in 2000. According to NIH itself, only four out of the 47 best-selling drugs were developed in part with NIH funding.

How much of the industry's spending on R&D goes toward new drugs? According to PhRMA, 78 percent is spent on innovative new products. More than 400 new medicines for cancer, 122 for heart disease and stroke, and 24 for Alzheimer's are undergoing testing as this article is written.

Is this record "good enough"? No one can say how many new drugs "should" be discovered each year. We do know that regulations requiring extensive testing of new drugs before they can be marketed, discussed below, lengthen the time it takes for a newly discovered drug to reach the market and dramatically increase the cost.

It may also be true that as medicine finds more cures for more diseases, the "easy" diseases disappear from the list, and those that remain are tougher and take longer to find a cure. Another possibility is that many diseases without cures affect smaller populations, making it more difficult for drug companies and investors to justify the high cost of getting a drug approved.

New and Improved?

According to a study from a managed care advocacy organization cited by Jennings, 80 percent of "new" drugs are not "significantly different" or "proven to be more effective" than drugs already on the market. But it is impossible even for experts, much less television commentators, to characterize most or even some changes to prescription drugs as being medically "insignificant."

Some of the doctors interviewed for the program did not think some new drugs are better than others. If he had wanted to present balanced coverage, Jennings easily could have found very respected doctors who believe some of the new drugs *are* better than others.

Doctors have different opinions about the best drugs and therapies available. That's not greed or conspiracy; it's medicine. No two patients are exactly alike, and no two doctors have past experiences so similar that they will always make the same diagnoses or prescribe the same medicine. In cases such as depression, where symptoms can change over time and are often elusive, the only way to determine the best drug for a patient is by trial and error.

One of the doctors interviewed sneered at the fact that one drug company had altered a drug so it needs to be taken only once a day. Yet, such a change is known to actually save lives. Getting patients, particularly those who are elderly, recent immigrants, or low income, to take their medication on a prescribed schedule can be very difficult. Moving from two pills a day to one, or one a day to one a week, improves patient compliance and can prevent serious medical complications.

Similarly, it is absurd to suggest that every new drug must be proven superior to drugs currently available before they can be sold. Such a requirement is imposed on no other industry because competition among producers, even of very similar or even identical goods and services, benefits consumers. It is by allowing producers to advertise the features and benefits of their products, and consumers to choose among firms competing to satisfy their wants, that markets produce the best

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products at the lowest prices.

Prohibiting companies from introducing new products unless a government bureaucracy declared them to be better than what is already on the market would be devastating to consumers and a violation of the rights of both consumers and producers. Should television commentators be required to prove their documentaries are better than those previously aired before being allowed to broadcast? Of course not.

Drug Patents and Generic Drugs

Jennings implied that patents provide drug companies with a monopoly so they can charge higher prices. However, later in the show he noted there are 170 drugs available for high blood pressure. Many of those drugs have existing patents. So which is it? Monopoly or strong competition?

The country's Founding Fathers thought intellectual property rights were so important that patents and copyrights are the only property rights affirmatively protected in the Articles of the U.S. Constitution (Article 1, Section 8). Yet, one talking head on "Bitter Medicine" called patents "a government patronage system." That's a radical view ... and just plain wrong.

"Yes, most of the drug companies are profitable, but no more so than many other companies in other fields."

Patents reward innovation by protecting inventors from competition during the 20 years following the granting of a patent. In the case of pharmaceutical drugs, approximately nine of those years will be taken up with testing, trials, and FDA delays. This leaves the companies with 11 years, on average, to recover their R&D expenses and earn a profit.

The patent system benefits consumers by giving inventors incentives to reveal the details of their discoveries so that others can study them during the patent-protection period and then imitate and improve on them after the patent expires. Without the protection of patents, many scientific discoveries would remain trade secrets and would be unavailable to consumers for much longer than 20 years.

Patents have worked well in the drug industry. Generic drugs—copies of the original patented drugs that are "bioequivalent," meaning they are absorbed into the body at about the same rate as the brand-name drug and produce the same effect—have increased their market share rapidly in recent years and now account for nearly 50 percent by volume of prescription drugs.

In many cases there are numerous patented drugs for the same medical condition (e.g., Claritin, Allegra, or Zyrtec for allergies; or Vioxx, Celebrex, or Arthrotec for pain). Just because laws prevent you from making a copy of Coca-Cola and marketing it as Close-a-Cola doesn't mean there isn't competition in the soft drink industry.

A Conflict of Interest

Jennings interviewed some doctors employed by Group Health and HMO Kaiser Permanente, who complained that Vioxx and Celebrex are no better than pain killers already on the market but cost 10 times as much. There is nothing about the current system of patents or drug pricing that prevents or discourages HMOs from giving their patients access only to older and cheaper drugs. There is more than a little irony, though, in Jennings' portrayal of these doctors.

Just a year or two ago, during the media-driven anti-HMO frenzy, few journalists would have shown sympathy for doctors working for HMOs claiming over-the-counter drugs are just as effective as expensive prescription drugs. Back then, Jennings would have demanded to know why the doctor was denying her patients the latest, most innovative drugs. Was it just to save money? Was she putting profits ahead of her patients' best interests?

The doctors from Group Health and Kaiser may have believed that over-the-counter painkillers are just as good as Vioxx and Celebrex, even for patients who might suffer from gastro-intestinal problems. But who is surprised when HMOs come up with reasons not to pay for new, more expensive drugs? That's why Congress has been trying to pass a Patients Bill of Rights for five years—because many members of Congress believe HMOs are inappropriately denying care.

New Drug Pricing

When any company releases a "new and improved" version of a product, most of us have a lingering suspicion that the only thing really new is a higher price. However, increasing competition is forcing drug companies to keep some prices lower. For example, after the release of the new generation of antidepressants such as Prozac in 1987, the "launch price" of the next six competitor drugs was between 7 percent and 45 percent less than the original. Schering-Plough priced its new drug, Clarinex, *lower* than the one it will succeed. Why? Competitors were hoping to gain market share over a more established and better known drug.

If Ford Motor Company came out with a new and improved car or truck and offered it at a lower price, consumers would be very pleased. Why, when drug companies do something similar, are they criticized?

Testing Against Placebos

Some of Jennings' interviewees complained that new drugs are tested against placebos rather than existing drugs. But there is a good reason for that: That is what the FDA wants. Drug companies have little control over the drug approval process, so criticizing them when they are playing by the rules doesn't make much sense.

The FDA's drug approval process requires new drugs to be safe and more effective than placebos, not more effective than existing drugs. Even achieving this level of quality assurance is astonishingly time-consuming and expensive: It requires nine years and costs more than $800 million to get a new drug approved in the U.S.

"Phase III" trials, in which a new drug is compared to a placebo, often include 2,000 to 3,000 patients at 20 to 30 academic medical centers around the country. Additional trials comparing the effectiveness of different drugs are very expensive; the number of patients has to be considerably greater and the duration of the trials is longer. A large number of such programs would have a considerable impact on the price of health care by consuming the time of thousands of doctors, nurses, and other support staff.

Are FDA-approved drugs unsafe? Problems and side effects that might not show up in a sample of 3,000 people may show up when 100,000 or a million patients use the drug. When that happens, the drug companies may change the warnings on the labels or sometimes pull the drug off the market. No one can know all the possible side effects until a drug is distributed widely.

Corruption and Fraud

One of Jennings' guests stated in strong terms that researchers are covering up side effects and problems because they make money off the research. However, research money from a drug company goes to the department of the medical school doing the research and does not enrich individual researchers. Moreover, researchers have to report back to the medical school's Institutional Review Board (IRB) that oversees human research. The IRB gets a regular statement of "adverse reactions" and the researchers' explanation for them.

If anything looks suspicious, the IRB can request an explanation or stop the protocol. Sometimes the researchers stop it. But these trials typically involve 30 academic medical centers, 50 or 100 doctors, and perhaps hundreds of nurses and support staff. To imply that all of these scientists, administrators, doctors, and nurses are in the pockets of drug companies, and that their IRBs are all asleep at the wheel, is both insulting and ludicrous.

What Jennings Overlooked

There is, in fact, growing controversy over the FDA's clinical testing requirements, but it is not about the issue Jennings described.

Many medical ethicists believe clinical trials should compare a new drug to the standard of care (i.e., the drug most doctors would prescribe), especially in cases where use of a placebo could result in harm to the patient. Is it ethical to let patients with a serious mental illness go eight to 12 weeks without any active drug to control their condition, considering such people can be a threat not only to themselves but to others?

There is also mounting concern that the FDA is simply too slow and too risk-averse to act as a tribunal over the fast-paced and high-tech pharmaceutical drug industry of the 21st century. Henry I. Miller, M.D., a senior research fellow at the Hoover Institution and former FDA official, says "if we can end regulatory excesses, introduce competition into regulatory oversight, and redirect government involvement to those few activities where a central monopolistic role is essential, more patients will benefit from a greater number of drugs made available to them in a timelier way."

Conclusion

Whether one drug is better than another is, and ought to be, decided by patients in consultation with their physicians. Only they can decide whether the trade-offs of benefits, costs, and risks are worthwhile. "Bitter Medicine" was full of people attempting to second-guess patients and their doctors. We should not go down that road.

"There is also mounting concern that the FDA is simply too slow and too risk-averse to act as a tribunal over the fast-paced and high-tech pharmaceutical drug industry of the 21st century."

The underlying theme of Peter Jennings' program was that everyone—doctors, regulators, members of Congress, and especially patients—is getting duped by drug companies. Everyone, that is, except for Peter Jennings and the handful of people he interviewed. This is obviously implausible and demonstrably wrong. Jennings is the one who was duped, by a small group of anti-industry activists.

Jennings concluded the program by calling for the federal government to "close the loopholes" in patent law and FDA regulation of new drugs. There are few if any such "loopholes" to be closed. He conveniently overlooks the fact that too much heavy-handed and inept federal regulation has caused many of the country's health care problems.

Can Jennings point to a case where more federal regulation has improved health care? Is Medicare a good example? That government-run health care program is so badly run doctors and other providers are fleeing! No, American health care consumers don't need more of that bitter medicine.

Merrill Matthews Ph.D. is a senior fellow with The Heartland Institute, an assistant editor of Health Care News, *and a senior fellow with the Lewisville, Texas-based Institute for Policy Innovation.*

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Health Care Market Disrupted in Kansas

BY CONRAD F. MEIER

State insurance officials have established a task force to find out why insurance companies are leaving Kansas and what can be done about it.

During 2001, several national insurance providers stopped offering individual medical coverage in Kansas, a development that is hurting more than 11,000 state residents. The lack of competition in the state's insurance market is having an inflationary effect, hurting even those consumers whose providers haven't left the state.

Kansas Insurance Department (KID) officials and insurance company spokespersons note similar problems plague other states. Over-bearing regulations imposed on the individual health insurance market are inflating insurance costs and making the individual medical insurance market unprofitable.

"I have no doubt it's a business decision," says Matt All, KID assistant commissioner. "Companies are finding it really difficult to make a buck right now in the individual medical market because of rising medical costs." Industry experts, however, say insurers are leaving because of a difficult and expensive regulatory environment.

"Over-bearing regulations imposed on the individual health insurance market are inflating insurance costs and making the individual medical insurance market unprofitable."

"Sometimes you hear insurance agents say that Kansas is more difficult to deal with than other states," says Larry Magill, executive vice president of the Topeka-based Kansas Association of Insurance Agents, a group of about 2,500 independent insurance agents. "I've heard stories that companies were leaving because they couldn't get rate increases, or couldn't get them fast enough."

Kansas Not Alone

Individual medical insurance plans provide health insurance coverage for people who are not part of a group plan offered through an employer. KID's All says about 11 percent of the Kansas population—twice the national average—is covered by this type of insurance.

Since April 2001, at least seven national insurance providers have notified the state insurance department they will not renew existing individual medical insurance plans. Others have suspended sales or marketing efforts, although they will continue to administer existing policies.

John Bouslog, in-house counsel for National Travelers Life Co., says his firm did not renew about 1,850 major medical policies issued to Kansas individuals. "It did not prove to be a profitable business," he explained.

Mutual of Omaha Insurance Co. also did not renew its individual hospital, medical, and surgical expense plans last year, a move that affected about 800 Kansas policyholders. "We pulled out of the individual major medical business in Kansas because we were unable to maintain a viable product in the state," says spokesman Joe Clauson.

"We had a very small policyholder base in the state," says Paul Burkett, vice president of corporate relations at American Republic Insurance Co., which suspended Kansas sales of individual medical policies late last year. "It was a business decision."

All notes Kansas is not the only state to be losing individual medical coverage. He says the seven companies leaving Kansas also left other states about the same time. "To my knowledge, not a single company has left Kansas that hasn't also left other states," All says.

Rate Complaints

All says health care costs are rising at double-digit rates. As a result, KID has tried to strike a balance between allowing insurers to raise rates to cover costs and protecting Kansas consumers from high rates.

Magill, however, says recent federal and state insurance reforms, mandates, and regulatory compliance burdens have added to the problem for insurers. Some states have adopted legislation prohibiting carriers from denying coverage or charging high rates to individuals because of previous health care expenses or pre-existing conditions.

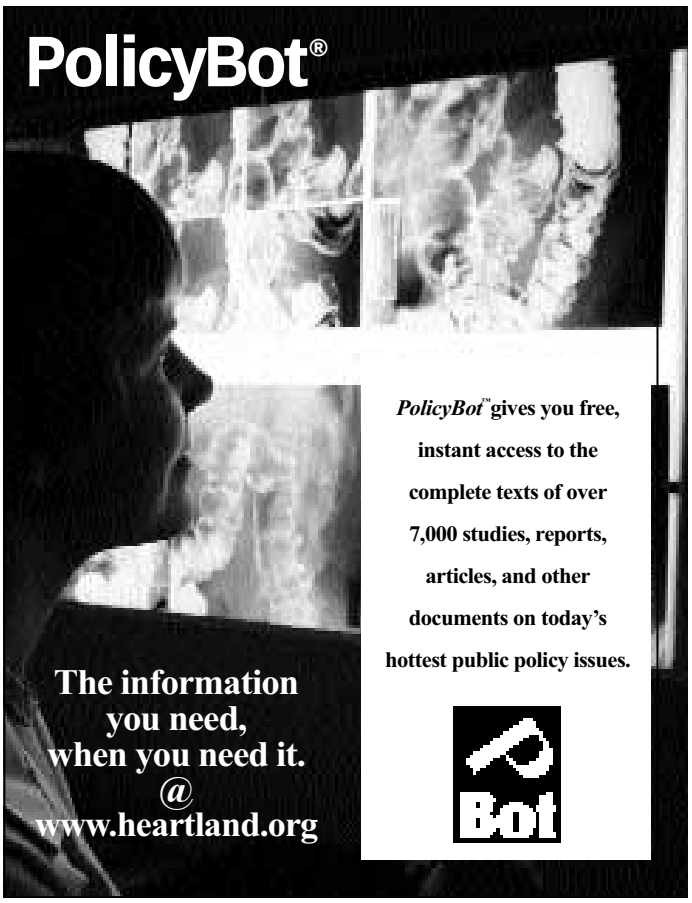
Burkett says the Kansas regulatory environment does not help the situation. "As any company, we would like to have a favorable regulatory climate allowing us to get the rate increases we need," he says. "Evidently, we had a difficult time getting the rate structure we felt we needed to get." All says most complaints are based on rate increase requests.

The state insurance department sees the issue differently. According to All, "I don't think this is a regulatory issue. Some companies didn't get a rate increase as quickly or as easily as they wanted, but we feel it's also important to keep rates fair for Kansans."

Task Force Named

Magill says Kansas is now trying to streamline some processes and do a better job of dealing with insurance providers and agents. All has recently suggested the department issue clearer guidelines for carriers filing for rate increases and more complete explanations of why requests are denied. There was no mention of any efforts to review the state regulatory environment.

The task force organized late last year, which includes several insurance agents from around the state, has not yet made specific plans. Most likely the group will start by approaching the insurance companies who left the Kansas health insurance market and ask what it would take to bring them back to the state.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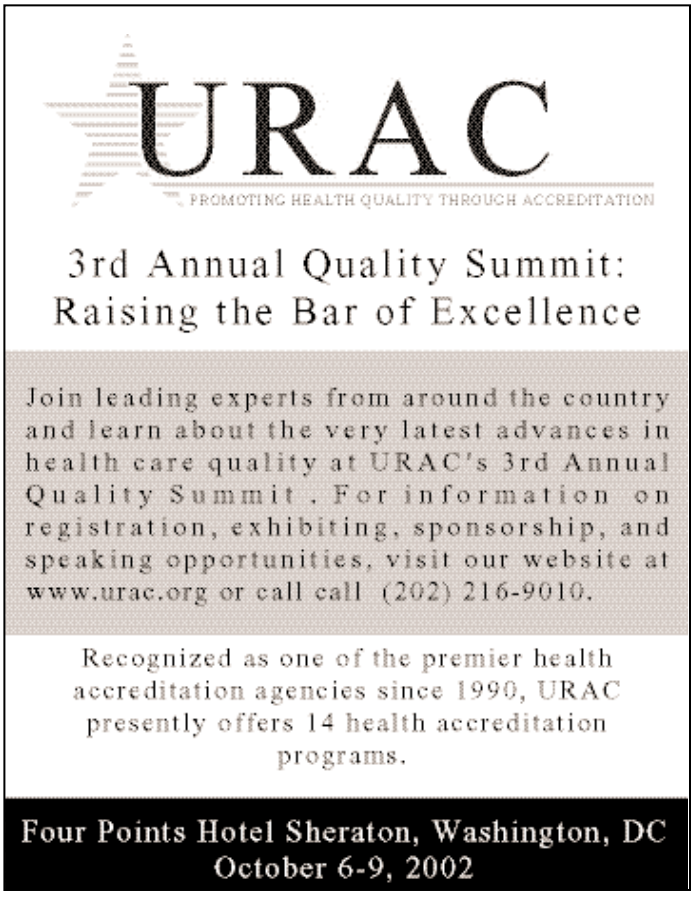
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Senator Debbie Stabenow (D-Michigan) speaks at a press conference on July 16. Her bill would allow states to regulate drug prices. *photo:http://stabenow.senate.gov/*

REBATES continued from page 1

legal authority to demand supplemental rebates from prescription drug companies. The Stabenow Medicaid Amendment would allow other states to follow the lead of Maine, which in 2000 adopted a program requiring drug companies to negotiate price discounts for low-income residents who do not qualify for Medicaid in exchange for having their products included in a state-authored list of pre-approved drugs.

In June, the U.S. Supreme Court agreed to hear a legal challenge to Maine's program filed by the Pharmaceutical Research and Manufacturers of America (PhRMA), which had appealed the case to the Supreme Court following rejection of its suit by the 1st Circuit Court of Appeals. The Court is not expected to hear the case before October.

Other state efforts to impose supplemental rebates on drug companies are also facing litigation. According to Sen. Debbie Stabenow (D-Michigan), author of the amendment, "It is my hope that my Rx Flexibility for States Act will get these programs out of court and provide lower prices for those who need them most. In the face of soaring prescription drug prices, states should be able to do all they can to pass on Medicaid rebates to their residents."

According to PhRMA President Alan F. Holmer, "the Senate vote for the Stabenow Amendment is a setback for patients. We strongly oppose the amendment because it could restrict access to medicines for millions of Medicaid patients. Senator Stabenow's measure would put state bureaucrats, not doctors, in charge of medical decisions for Medicaid patients and would force Medicaid patients to the back of the line when it comes to state-of-the-art medicines."

Looking for an outstanding speaker?

Who is Dr. Merrill Matthews?

Merrill Matthews Jr., Ph.D., is a Heartland Senior Fellow specializing in health care policy and a visiting scholar with the Institute for Policy Innovation. Dr. Matthews is past president of the Health Economics Roundtable for the National Association for Business Economics, the largest trade association of business economists, and health policy advisor to the American Legislative Exchange Council, a bipartisan association of state legislators.

Engagements are scheduled on a "first come, first served" basis, so call 312/377-4000 today to schedule Dr. Merrill Matthews to keynote your next event!

For more information…

WWW **"Florida's Folly: The Darker Side of the Sunshine State's Drug-Pricing Scheme,"** by William Orzechowski and Robert C. Walker, is available through *PolicyBot*. Request document #3264104.

Rebates and Formularies

Federal law already requires that drug manufacturers charge state Medicaid programs the lowest price of any domestic, non-federal purchaser of prescription medicines, including wholesalers and HMOs, in return for the privilege of having their drugs included in a federal list, or formulary, of drugs approved for Medicaid reimbursement.

Under the Medicaid Drug Rebate Program, created in 1990, manufacturers of brand-name drugs sign national rebate agreements with the federal government paying either a rebate equal to 15.1 percent of the average manufacturer's price (AMP) or the difference between the AMP and the best price, whichever is greater. An 11 percent rebate is paid for generic drugs.

Drug companies agree to sign the rebate agreements because being excluded from the formulary means doctors must get special permission from state authorities (called "prior authorization") before prescribing the drug. Many doctors switch patients to second-choice drugs to ensure reimbursement by Medicaid and avoid the delays and paperwork of the approval process.

Some 500 drug manufacturers have signed federal rebate agreements, and 1,827 brand-name prescription drugs are included in the federal formulary. According to industry sources, the pharmaceutical industry paid $16 billion in Medicaid rebates between 1991 and 1999, and $3.3 billion in 1999. States received about $1.4 billion in rebate payments in 1999.

The debate over supplemental rebates arose when California, Florida, and Michigan sought to extract further concessions from brand-name drug manufacturers by requiring rebates in addition to those required by the federal agreements, and for persons other than those eligible for Medicaid. The name-brand drug industry has argued that a drug cannot be removed from a state's Medicaid formulary unless it lacks "a significant, clinically meaningful therapeutic advantage" over other drugs in the formulary, and unless an explicit waiver has been issued by the Secretary of the U.S. Department of Health and Human Services.

According to Merrill Matthews, a senior visiting scholar for the Institute for Policy Innovation, "Senator Stabenow's amendment would authorize every state to require drug manufacturers to provide their lowest prices not only to the Medicaid program but also to everyone else. This would create a regime of price controls throughout the nation by mandating, in effect, that all drugs be sold only at the lowest price at which a company sells to any purchaser within the U.S."

Impact on Consumers

Many physicians and health policy experts warn that using restrictive formularies to control spending on prescription drugs is poor public policy. Formularies are often made obsolete by the release of new drugs, denying Medicaid patients access to the latest and best drugs. Access to drugs by the poor is, in effect, being held hostage in order to negotiate price concessions from drug companies.

Requiring prior approval is often time consuming and expensive even under the current regime, posing a risk to the health and safety of patients. "Anytime you go to a prior-approval process, the bureaucracy is unbelievable," Randy Miley, senior vice president of LifeStream Behavioral Center, a hospital for the mentally ill in Lessburg, Florida, told the *Orlando Sentinel*. "A patient shouldn't have to wonder whether they are getting their medications."

Florida's experiment with supplemental rebates has been closely watched. Preliminary results confirm the fears of the program's opponents. Dr. Cyneetha Strong-Smith, a member of the Pharmaceutical and Therapeutics Committee responsible for creating the state's new formulary, told the *Orlando Sentinel* that the state's Medicaid bureaucracy in the past sometimes didn't return phone calls asking for prior approval. "Practically and realistically, my experience is it has just not worked," she said.

Selecting which drugs to include in Florida's formulary has become a political as well as medical exercise, with lobbying groups for the mentally ill and AIDs patients demanding that all drugs used by their constituents be automatically reimbursed under Medicaid. The arguments used are good ones–not all mentally ill patients respond the same or at all to many psychiatric drugs, and AIDs patients often need "cocktails" of many different prescription drugs–but hardly unique to patients of these types. Many patients react differently to many drugs, and giving doctors and patients the flexibility to experiment with different drug regimes would benefit them all.

In June, the Pharmaceutical and Therapeutics Committee announced that 71 psychiatric and HIV drugs would be placed on the formulary because their manufacturers agreed to pay supplemental rebates. Advocates for the mentally ill and AIDs patients were furious because access to drugs not on the formulary is likely to be delayed or restricted by doctors who believe the drugs are not covered by Medicaid.

Price controls and forced rebates artificially inflate demand for prescription drugs by insulating customers from the true cost of the drugs they choose to buy. In the case of seniors, many of whom take multiple prescription drugs, this poses a genuine threat to public health. Michael Arnold Glueck M.D. and Robert J. Cihak M.D. point out that 10 to 20 percent of hospitalizations of seniors are the result of drug side effects and unexpected interactions.

According to Glueck and Cihak, "No physician can completely understand all the interactions possible when multiple drugs are used." Reducing drug prices across the board will compound what is already a growing public health problem.

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IRS continued from page 1

gram as part of their benefit packages. The [prior] inability to get even private letter rulings verifying the HRA approach has inhibited many employers from adopting consumer-driven health benefits programs."

"This will just open the floodgates and finally allow employees to manage their own health care," agreed Marianne Fazen, executive director of Dallas-Fort Worth Business Group on Health, a coalition of 130 large employers.

No More "Knots"

While many employers say they support consumer-driven plans as a way to curb health care inflation, few offer such plans. Industry leaders say the main obstacle had been the uncertainty of the tax status of benefits carried over from year to year. With that obstacle eliminated, employers are expected to embrace ... and act on ... the idea of consumer-driven health care.

Responding to news of the ruling, Grace-Marie Turner, president of The Galen Institute, wrote, "Remember how Sen. Ted Kennedy tied Medical Savings Accounts into knots in the 1996 legislation, allowing only 750,000 of the policies to be sold (too few for a real market to emerge) and strictly limiting their terms?

"Well, this new ruling will allow millions of employers to offer a new form of Medical Savings Account to tens of millions of workers. And workers and their employers, not Sen. Kennedy, will decide the terms."

"This is the revolution we all have been waiting for, and this IRS ruling—not an act of Congress—was the key."

GRACE-MARIE TURNER
PRESIDENT, THE GALEN INSTITUTE

Insurance companies, the primary provider of MSA-type plans, now have a viable market for consumer-driven products. Before the IRS guidance, the uncertainty of the tax consequences prevented many companies from marketing MSA plans.

Scandlen points out, "clever vendors who do a good job of packaging the products, provide excellent customer service, and guarantee compliance support for employers, will do very well in the market. The vendors who cannot provide a full-service product probably will not do so well."

According to Turner, "This is the revolution we all have been waiting for, and this IRS ruling—not an act of Congress—was the key. This is true jujitsu: The IRS, the tax exclusion for employment-based health insurance, and ERISA suddenly are our friends. Imagine that."

"There are a lot of nuances in how these new policies will be shaped," says Turner, "involving incentives for preventive care and networks of doctors that agree to lower rates in return for direct payment. But blessedly, companies, and not Washington, will be in charge of making those decisions."

How it Works

Some workers will choose to stay with a managed care arrangement, like a PPO or HMO, but others will opt instead for the MSA-type accounts, which the IRS calls HRAs, or Health Reimbursement Arrangements.

An employer would deposit part of the money it had been spending on health insurance premiums for an employee into an account the employee could use to pay routine medical bills. The employer would also purchase for the employee a catastrophic insurance policy to cover major medical bills. If an employee's annual health care cost exceeds the funds in the savings account, traditional health insurance with high deductibles kicks in.

The key element of the IRS ruling allows employees to roll over from one year to the next any amount in the account they have not used. Employees can continue to access the money even after they leave the company or retire.

"While funds can't be rolled over when an employee changes companies, an employer can set up a plan so that the employee can leave and still have access to the unused funds," said Bill Sweetnam, benefits tax counsel with the Treasury Department, which oversees the IRS.

There is no cap on the amount employers may contribute to consumer-driven accounts, and the contributions may vary by company. As Scandlen explains, "An HRA may accompany any type of insurance plan, not just a high-deductible one. So an employer could set up an HRA with just $100 contributed every year to help offset an HMO's copayments, or an employer could establish a truly high-deductible plan of $6,000 and provide a $5,000 annual HRA allowance.

"An employer has wide flexibility in designing an affordable benefits package," explained Scandlen. "It could provide first-dollar coverage for some medical services, coinsurance for others, and a deductible for still others, and use an HRA to fill in whatever gaps exist."

Allowing employees to access the funds in their account even after they have left their employer could help them pay COBRA continuation premiums or purchase individual insurance, noted Scandlen. Such access should also help retirees meet their medical expenses.

Cooling off Inflation

With clear guidance from the IRS and favorable results from the handful of pioneering employers who had success with this approach even before the IRS ruling, most industry observers expect a rush by employers to adopt some version of HRA for the 2003 enrollment year.

Fortune magazine recently reported how Humana was able to curb its internal health insurance expenses by offering HRAs to its employees. Humana may see its insurance rates rise as little as 3.7 percent this year, while other employers are facing rate increases of 20 percent or more.

Tax Relief Makes Health Care More Affordable

BY HON. PHILIP M. CRANE

Rising health care costs are a major concern for many Americans. Whether it is the increased costs of health insurance premiums or the high cost seniors must pay out of pocket for their prescription drugs ... if it is unaffordable, many will go without necessary treatment.

Earlier this year, I introduced the Medical Cost Deduction Act of 2002, H.R. 4001. It makes health care more affordable by allowing individuals to deduct most of their medical expenditures that exceed 2 percent of their Adjusted Gross Income (AGI).

Since 1942, taxpayers who itemize have been eligible to take a medical deduction for health care costs in excess of a percentage of their adjusted gross income. Current law allows taxpayers to deduct health care costs in excess of 7.5 percent of their AGI. This is a relatively high threshold, one that few taxpayers who itemize can take advantage of.

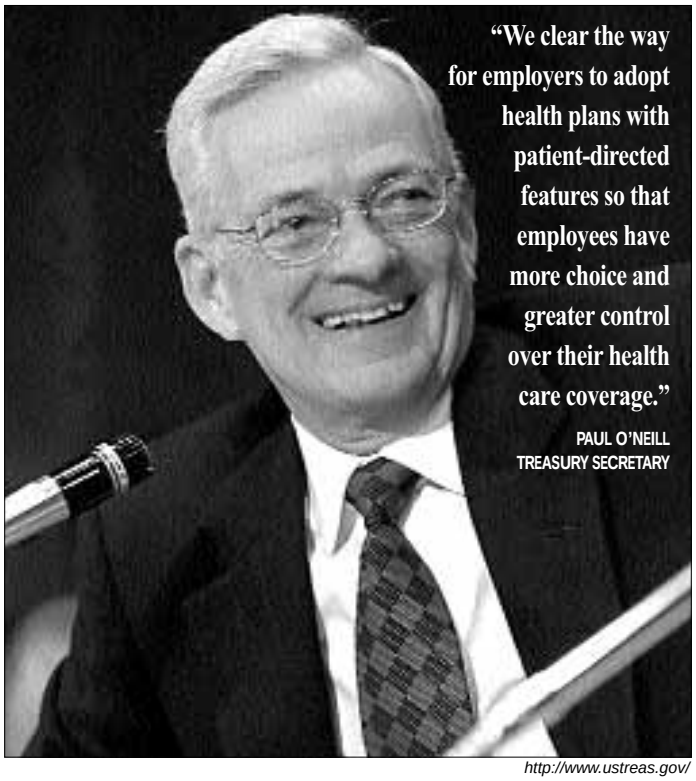
Under the current 7.5 percent threshold, a taxpayer with an income of $30,000 can deduct out-of-pocket health care costs only when they exceed $2,250. Under my proposal, that same taxpayer will be allowed to deduct health care costs above $600.

"The last time the threshold for deductibility of health expenses was lowered was almost 50 years ago in 1954, when Republicans last had control of the House of Representatives."

The last time the threshold for deductibility of health expenses was lowered was almost 50 years ago in 1954, when Republicans last had control of the House of Representatives. Back then, the threshold was lowered from 5 percent to 3 percent. The House Committee on Ways and Means included in its report on the legislation that there is a "general agreement that limiting the deduction only to expenses in excess of 5 percent of AGI does not allow the deduction of all extraordinary medical expenses."

Health care is far more expensive today than it was in 1954, and it is safe to say that limiting the deduction only to expenses in excess of 7.5 percent of AGI does not allow the deduction of all extraordinary medical expenses. By lowering the deduction for medical expenses to 2 percent of AGI, H.R. 4001 aims to help families cope with the increasing costs of health care.

Republican Philip M. Crane represents Illinois' 8th Congressional District.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WWW See the U.S. Treasury press release at **http://www.ustreas.gov/press/releases/po3204.htm**. The release links to the full text of the new guidance.

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State Legislative UPDATE

COMPILED AND EDITED BY CONRAD F. MEIER

ARIZONA

Arizona's Premium Sharing Program, a pilot program covering the cost of physician visits and medicines for low-income and chronically ill residents, has stopped accepting new applicants because of budget cuts. The program was designed to assist residents with incomes of up to 250 percent of the federal poverty level ($2,419 per month for a couple) and those with chronic illnesses whose incomes were no more than 400 percent of the poverty level ($3,870 per month for a couple).

Originally, the program operated on a $20 million annual budget, but in July its budget was nearly halved, to $10.5 million per year. As a result, the program has frozen its enrollment and is attempting to transfer many of its current 6,000 participants into other health programs.

MASSACHUSETTS

Gubernatorial candidate Steve Grossman (D) has proposed a plan requiring pharmaceutical companies to publicly disclose the names of doctors who accept gifts valued at $25 or more. The proposal would authorize state officials to fine drug makers as much as $10,000 for each unreported gift to doctors valued at more than $25.

A similar measure was introduced in this year's legislative session. Lawmakers in Maine, New York, and Wisconsin have also introduced similar bills, while Vermont already has such a law.

"The public has a right to know who's spending the money and who's receiving it. It is affecting decisions costing people a lot of money and possibly affecting care," Grossman said. Grossman's Democratic rival Robert Reich, a former U.S. secretary of labor, has called for an "outright ban" on gifts from pharmaceutical companies to doctors.

Critics of the proposals say they interfere with the right of pharmaceutical companies to inform doctors of their products, and giving free samples is a common practice in other industries.

MICHIGAN

Michigan state health officials recently "reminded" local health departments that children whose health plans cover vaccines may not receive free inoculations from local health departments.

Traditionally, local health departments in Michigan have immunized all children free of charge, using discounted vaccines purchased from the federal government. Although federal law has long precluded children whose insurance covers vaccines from receiving free vaccinations from local health clinics, the law has gone largely unheeded in Michigan. Now state officials say the rule must be enforced to save money.

MINNESOTA

Minnesota Attorney General Mike Hatch (D) filed a lawsuit in Minneapolis-based Hennepin County District Court claiming Pharmacia charged doctors $7.75 per dose of the cancer treatment Vincasar, but listed the Average Wholesale Price (AWP) as $742.50.

For Medicare purposes, prescribing doctors are reimbursed 95 percent of the AWP: roughly $705 for Vincasar. Medicare itself typically would pay 80 percent, about $564, and beneficiaries would pay the remaining 20 percent, or about $141, Hatch said.

Prescribing physicians have been allowed to keep the difference between the $7.75 they paid to Pharmacia for the medication, and the $705 they were reimbursed by Medicare. That practice, the lawsuit alleges, "created an incentive" for doctors to choose certain chemotherapy drugs over others. The suit seeks between $5 and $10 million in reimbursements from Pharmacia, some of which would go directly to patients who allegedly overpaid for the medications.

Hatch said he expects the National Association of Attorneys General to "not be far behind in taking action" against pharmaceutical companies nationwide. But John E. Calfee, a health scholar at the American Enterprise Institute, questions the legal basis for such suits. "Not only have Congress, HHS and other parties been aware of how AWP works, Congress and HHS have made AWP part of pricing arrangements through legislation or regulation."

MISSOURI

Missouri State Auditor Claire McCaskill claims her state could save more than $50 million a year on Medicaid drug costs if it employed a preferred drug list and lowered the reimbursement rate it pays pharmacies. Medicaid prescription drug costs in Missouri have more than doubled since 1997, reaching $660 million in 2001. "Missouri has not been as proactive as other states with certain containment programs," according to McCaskill.

Although state legislators passed a law this year permitting a preferred drug list, the state's complex rule-making process blocked its implementation. The rule-making process has also precluded implementation of a prior-authorization program, under which doctors would have to receive permission from the state before prescribing certain drugs.

The Division of Medical Services is crafting a preferred drug list and attempting to change the state's rule-making process to make way for a prior-authorization program.

TENNESSEE

To comply with a judge's order, TennCare officials have spent $136,000 since June 13 to sign up new applicants for the program ... even though they will lose coverage if state lawmakers elect not to fully fund the program.

Last year U.S. District Judge William Haynes ordered the state to open TennCare enrollment when slots became available; accordingly, the state has mailed information packets to 220,000 individuals who previously had been rejected for TennCare benefits, inviting them to apply for about 5,000 slots vacated by individuals found ineligible.

TennCare lawyers called the process a "futile exercise," saying the new beneficiaries may lose their coverage when the state's recently approved Medicaid waiver takes effect. The waiver restructures eligibility and benefits and allows the state to create three separate programs: TennCare Medicaid; TennCare Assist, which would provide low-income workers assistance in purchasing private health insurance; and TennCare Standard, for people with high-risk medical conditions as well as low-income adults and families with no access to group insurance.

State Deputy Finance Commissioner John Tighe, who oversees TennCare, said up to 420,000 beneficiaries could lose coverage if lawmakers decide not to fully fund TennCare.

TEXAS

A Dallas County jury ordered Cigna Healthcare of Texas to pay $13 million in damages to the family of a Texas man who died after the HMO "forced him out" of a skilled nursing facility, marking the first jury award allowed under the state's patients' rights law.

Herschel Pybas, a member of Cigna's Medicare+Choice plan, was admitted to a skilled nursing facility in 1998. He had congestive heart failure and renal failure and a history of stroke, anemia, upper respiratory infection, and malnutrition. According to the lawsuit, Pybas was "forced out" after less than one month in the facility.

Cigna indicated it would provide nursing care for Pybas at home. One day after being released, Pybas was taken to the hospital in "grave condition." He died five days later.

In 1997, Texas passed the first-in-the-nation law allowing patients denied medical care to sue their HMOs. Between 20 and 30 suits have been filed, several of which were settled out of court. The only other case to go to trial ended in a victory for the HMO.

WASHINGTON

U.S. Secretary of Health and Human Services Tommy Thompson approved a Washington state program to allow people with disabilities to retain Medicaid coverage after returning to work. Under the program, Medicaid benefits will be available to all disabled people ages 18 to 64 with annual incomes up to 220 percent of the federal poverty level, or $19,492 for an individual.

State officials say they expect about 400 people to qualify for the program during the first year and about 1,100 by September 30, 2003. To implement the program, the state has received $1.125 million from Medicare under the Ticket to Work and Work Incentives Improvement Act of 1999.

"Now, hundreds of Washington state residents will be able to return to work without fear of losing access to medical care for a serious disabling condition," Thompson said.

The State Legislative Update is compiled from a wide range of news sources, including the Council for Affordable Health (CAHI) http://www.cahi.org; the National Association of Health Underwriters (NAHU) http://nahu.org; Bizjournals at http://bizjournals.com; Stateline at http://stateline.org; and Lexis/Nexis research.

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The Galen REPORT

A monthly review of health policy matters

As Congress investigates the investigators about what intelligence the FBI and CIA had before the September 11 attacks, we see rising concern about our lack of preparedness for the next potential attack with biological weapons.

Many experts warn we are wasting valuable time in preparing ourselves for one of the most lethal and deadly weapons: smallpox virus. Unlike anthrax, there is no cure. The only protection is immunization.

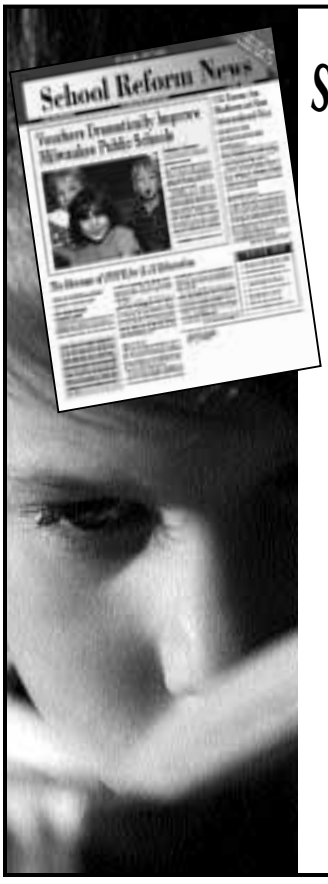
The Cato Institute held a powerful forum providing chilling evidence that the federal government, which controls all of our stores of smallpox vaccine, will not be able to respond in time to distribute the vaccine and inoculate millions of people after an attack, as is its current plan.

It is imperative the government change its strategy to allow people who want to be vaccinated to do so now. A recent Robert Wood Johnson Foundation survey said 59 percent of Americans would be vaccinated for smallpox if the government would release the supplies.

The *Washington Post* recently reported on the smallpox threat and a series of forums giving the public a chance to have its say. The Bush administration wants a recommendation from the Centers for Disease Control.

Separately, Robert Goldberg of the Manhattan Institute hosted a Capitol Hill forum on "Medical Progress and the FDA: Our Future is in the Balance." The theme was the need for reform of federal policies to keep pace with evolving science and technology in the pharmaceutical industry. For example, as medications can be tailored to an individual patient's needs, the concept of massive clinical trials will be obsolete. The Food and Drug Administration should shift its focus to safety testing to allow researchers to make this next giant leap in medical progress.

Grace-Marie Turner



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RECENT PUBLICATIONS

The House Medicare Bill: a Proposal Only a Politician Could Love

Jeff Lemieux

Jeff Lemieux of the Progressive Policy Institute says the Medicare prescription drug bill crafted by House Republicans "fails on several levels: the drug benefit is unlikely to work [because of adverse selection], the stand-alone design would further balkanize seniors' health coverage and thereby thwart Medicare reform, and new price controls would push problems into the future, rather than working to solve them now."

Lemieux calculates the net benefits for seniors at different drug spending levels under the plan. He finds the maximum net benefit for those with annual total drug expenses between $2,000 and $5,600 to be $680 after taking the premium, deductible, and coinsurance into account. If seniors had drug expenses of $500 per year, they would actually *lose* $220 by signing up for the program.

He finds only those with the highest drug spending (above $5,600) would have much to gain by entering the Republican drug plan.

As an alternative, Lemieux proposes a zero-premium, high deductible, catastrophic-only drug plan that would be mandatory for all Medicare beneficiaries and would thus avoid the pitfalls of adverse selection while fitting into tight budget constraints.

Source: http://www.ppionline.org/ppi_ci.cfm?knlgAreaID=111&subsecid=141&contentid=250584

Patent Protection for Me, But Not for You

Dr. Merrill Matthews, Jr.

Merrill Matthews takes on Business for Affordable Medicare (BAM)—the coalition of big employers, labor unions, and governors—for fighting aggressively to defend their own patents while trying to undermine pharmaceutical companies' patent rights.

"The real issue driving the BAM coalition is drug cost," Matthews writes. "Prescription drug utilization has been rising across all segments of the population for years—because there are more drugs to treat more illnesses." BAM's mission is to open up the Hatch-Waxman Act to allow speedier access to generics.

However, since passage of Hatch-Waxman in 1984, domestic pharmaceutical research and development spending grew from $3.4 billion in 1985 to about $23.9 billion in 2001. Matthews argues the generic industry has also prospered under this act, with its market share going from 19 percent of volume in 1984 to 47 percent in 2000. "Undermining [pharmaceutical patent] protections won't increase competition and lower costs, it will increase costs and kill innovation," he concludes.

Source: http://www.galen.org/news/Patent_Protection.pdf

Pharmaceutical Innovation: Lowering the Price of Good Health

Neal A. Masia, Ph.D.

Economist Neal Masia of Pfizer cites in this monograph a wealth of research that quantifies the value of pharmaceutical innovation in improved health, economic performance, and quality of life. For example, one study he cites found that AIDS "treatment costs per patient fell by nearly $300 per month after introduction of the first cocktail in 1997, despite the increase in drug costs."

Further, new treatments for Alzheimer's disease are initially costly, but they help patients avoid or reduce nursing home care over a period of time to save thousands of dollars per patient. He also cites evidence of overall cost savings from drug treatments for asthma, migraine headaches, heart disease, depression, influenza, and others.

Masia concludes, "Public policy initiatives can and should assist those in need without jeopardizing the market reward structure that has reliably fueled medical advances of nearly incalculable value."

Source: http://www.pfizer.com/pfizerinc/policy/er22.pdf

The Role of Federal Government in Healthcare Reform

Grace-Marie Turner and Quentin Young, M.D.

The BlueCross BlueShield Association offers an information-packed Web site, including a "Point-Counterpoint" debate on health policy issues. The current series features free-market advocate Grace-Marie Turner and government-control advocate Dr. Quentin Young, who is national coordinator of Physicians for a National Health Program.

Each installment in the series allows the authors to share their viewpoints regarding the successes and failures of the government's involvement in the health care insurance system, the most appropriate role for government in the health care delivery system, and what role government should play in helping to reduce the cost of health care.

Source: http://www.bcbshealthissues.com/perspectives/

Material for this report is provided by The Galen Institute, P.O. Box 19080, Alexandria, VA 22320, http://www.galen.org. Grace-Marie Turner is president. This report is produced by Elizabeth Lamirand, who can be reached at 703/299-9550, and edited by Conrad F. Meier, managing editor of Health Care News.

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My TURN

BY CONRAD MEIER - MANAGING EDITOR

A Good Idea Going Bad

On July 23, the U.S. Senate voted against two rival bills that would have expanded Medicare prescription drug coverage for senior citizens.

This was a good thing, because both bills would have vastly increased the cost of Medicare without first reforming the worn-out senior health care system. The issue will now be debated for another year before action—good or bad—is taken.

Adding benefits without reforming the existing program will hasten the exhaustion of Medicare's Hospital Insurance (HI) trust fund and further drain general revenues. Expansion of Medicare will also serve to make the long-term fiscal challenges even greater.

With the retirement of 77 million baby boomers, Medicare will face a doubling of beneficiaries ... and a dramatic drop in the number of taxpaying workers contributing to the fund. Remember, Medicare is a wealth-transfer program.

Mountains of Paper

In addition to serious financial challenges, Medicare is plagued with costly governance problems characterized by the imposition of tens of thousands of pages of rules, regulations, and related paperwork. Those governance problems will subject a prescription drug benefit to complex administrative procedures and increased micromanagement by bureaucrats.

If prescription drugs become a Medicare benefit, their availability, the conditions regarding their delivery into the hands of consumers, and their pricing will be fixed within the sticky web of Medicare's legendarily complex rules.

The Lewin Group, a prominent econometrics firm specializing in health policy, reports it takes anywhere from 15 months to more than five years for Medicare to provide seniors with access to new medical technologies. Medicare patients are routinely denied access to newer and advanced medical treatments available to Americans in private-sector health plans. Without substantive Medicare reform, seniors' access to drug coverage will be similarly compromised by a sluggish bureaucracy.

Faux Pax

One unintended consequence is based on Congressional Budget Office estimates: Three-quarters of all seniors already have access to prescription drug insurance, and about one-third have prescription drug coverage through employer-based retirement plans.

With the Medicare drug benefit, many of those seniors are likely to lose their current coverage. Why? Once employers realize taxpayers are going to be forced to pay for the drug costs of retirees, they will have a powerful incentive to drop retirees from private coverage, shifting the cost to taxpayers.

Adding to Medicare's current troubles, an expanded population of beneficiaries and an artificially low premium based on government cost control schemes will guarantee a sharp increase in prescription drug utilization. As was the case with the drug benefit included in the repealed Medicare Catastrophic Coverage Act of 1988, the real costs of Medicare's drug benefits will rise far beyond official projections ... and far beyond Congress' ability to provide funding without additional taxation.

More Taxes Please

According to Robert E. Moffit Ph.D., director of domestic policy studies at The Heritage Foundation, "Unable to deal with an exacerbated fiscal crisis in the Medicare program, Members of Congress will likely respond by holding high-profile hearings that provide them with an opportunity to blame government actuaries or drug companies for the 'unexpected' cost increases."

Moffit also predicts, "Congress will then be forced to choose among unpleasant options: raising seniors' Medicare premiums or deductibles to cover the soaring drug costs, imposing higher taxes on younger working families, or enacting a combination of premium and tax increases. They may also resort to the worst alternative: reducing the supply of drugs through cuts in drug reimbursement, tightening drug formularies, or instituting some form of price controls."

Clone the FEHBP

Instead of layering a drug benefit on top of a broken system, Congress should be acting on the 1999 recommendation of the National Bipartisan Commission on the Future of Medicare: Give all senior citizens a financially stable benefits package. The commission's recommendation is based on the model of the Federal Employees Health Benefits Program (FEHBP).

FEHBP beneficiaries choose from a variety of health plans, all of which cover prescription drugs. Most FEHBP health plans cover between 80 and 90 percent of prescription costs. No one must endure out-of-pocket premiums for supplemental coverage to compensate for the gaps in the current Medicare arrangement.

Seniors should have access to solid prescription drug coverage and a superior health care system in their retirement. The FEHBP is such a system, and it provides an attractive model for addressing benefit needs while reforming the Medicare structure.

The FEHBP provides health care and prescription benefits effectively for Members of Congress, the White House staff, and millions of federal employees and retirees. It has done so, by tapping the free market, for more than four decades.

That brings me to an obvious question: Why can't Congress clone the FEHBP to meet the needs of today's seniors and tomorrow's retiring baby boomers? If you can explain it to me, please write me at meier@heartland.org.

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Wednesday, September 18
Dedicated Hours
5:00 pm – 7:00 pm — Exhibit Hall—Grand Opening Reception

Thursday, September 19
Hall Open
9:30 am - 1:30 pm — Exhibit Hall Open
5:00 pm – 6:30 pm — Exhibit Hall Open
Dedicated Hours
9:30 am – 10:45 am — Exhibit Hall Open—Continental Breakfast
12:00 pm – 1:30 pm — Exhibit Hall—Lunch
5:00 pm – 6:30 pm — Networking Reception

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